June 28, 2001

Mr. Dennis Smith, Director
Center for Medicaid and State Operations
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Smith:

The Commonwealth of Massachusetts is pleased to submit this request for a three-year extension of Massachusetts' section 1115 demonstration project (No. 11-W-00030/1), entitled "MassHealth".

This request has been developed in accordance with the instructions of The Centers for Medicare and Medicaid Services (CMS). If approved, the extension period will run from July 1, 2002 through June 30, 2005. We call particular attention to the Budget Neutrality section, which begins at page 27. While the Demonstration will remain budget neutral over the first five-year period and continues to have a sizeable savings cushion, the Division is requesting an increased trend line going forward. Over the past year, medical service rates have begun to rise and are expected to continue to rise in the near future, particularly in regards to pharmacy expenditures. The Division continues to try to contain costs and utilization rates; however, we believe an increase in the trend line, especially for our disabled members, is essential to accurately reflect the rising costs that are expected over the three-year extension period.

We look forward to your response. If you have any questions or need additional information, please contact Beth Waldman at (617) 210-5371.

Sincerely,

Wendy E. Warring
Commissioner

cc: Ron Preston, Ph.D., Associate Regional Commissioner, HHS Region 1
William O'Leary, Secretary of Health and Human Services
Sharon Donovan, CMS Project Officer
Patricia Hitz-McKnight, Region 1

COMMONWEALTH OF MASSACHUSETTS
DIVISION OF MEDICAL ASSISTANCE

WAIVER EXTENSTION REQUEST

Submitted: June 28, 2001

TABLE OF CONTENTS

A. Supporting Documentation Provided By The State

1. Program Objectives

The Division of Medical Assistance is pleased to submit its request for federal approval for a three-year extension of its 1115 Demonstration Project that allows for the successful operation of the MassHealth program for the under-65, non-institutionalized population. The extension, if approved, will permit Massachusetts to continue operating its 1115 Demonstration from July 1, 2002 through June 30, 2005.

The Division began implementation of the MassHealth Demonstration Project on July 1, 1997. As shown in Table 1, through this Demonstration Project, MassHealth provides health-care coverage, either directly or by providing assistance in the purchase of private coverage such as employer-sponsored health insurance, to over 800,000 Massachusetts residents under age 65. The Division enrolled an additional 270,000 individuals in the MassHealth program under the Demonstration, while working to protect and increase coverage among the working poor and their families by promoting the purchase of private health insurance. Through the Insurance Partnership, formerly known as the Insurance Reimbursement Program, the Division provides premium assistance to members while offering incentive payments to small employers who participate in the program and provide access to health insurance to their low-income employees.

Table 1. Enrollment by Age Category (as of 5/31/01)

Population	Additional Members	Total Members
Adults (19-65)	170,527	422,067
Children (0-18)	99,474	405,306
Total	270,001	827,373

The Division gained approval of its Demonstration with the broad policy objective of increasing health-insurance coverage while curbing the growth of the Commonwealth's disproportionate share hospital (DSH) and uncompensated care pool expenses. During this period of increased MassHealth enrollment, the number of uninsured residents in the Commonwealth has been cut in half – from over 700,000 in 1996[1] to 346,000 today.[2]

Throughout the Demonstration, the Commonwealth has financed expanded health-insurance coverage for the state's neediest citizens in three ways: 1) by redirecting state-only expenditures and uncompensated care pool funds; 2) by utilizing revenues from increased cigarette taxes; and 3) by achieving savings in

[1] 1995, 1996, & 1997 merged Current Population Survey (CPS)
[2] Division of Health Care Finance and Policy *2000 Health Insurance Status of Massachusetts Residents Survey.*

per capita expenditures by placing greater reliance on managed care. Rather than funding health care for those with acute needs through safety net providers, the MassHealth Demonstration provides access for the low-income uninsured through managed-care delivery systems. This allows for better access and an emphasis on comprehensive, continuous and preventive care that improves the quality of care and reduces the need for costly emergency and hospital care.

Overview of MassHealth Coverage Under the 1115 Demonstration Project

Under MassHealth, the Division has a variety of coverage types to cover members under age 65; coverage types are determined based upon financial and categorical eligibility. The Division's significant expansion of coverage for children is accomplished through a combination of the Demonstration Project and the State Children's Health Insurance Program (SCHIP).

MassHealth Standard provides benefits to children under 19 whose gross family income is at or below 150% of the federal poverty level, the parents of children whose gross family income is at or below 133% FPL, pregnant women and children under age one whose gross family income is at or below 200% FPL, and disabled individuals whose gross family income is at or below 133% FPL. MassHealth Standard members receive the full Title XIX benefits package. Benefits are generally provided either through contracted managed care organizations (MCOs) or through a managed care plan administered by the Division (the Primary Care Clinician, or PCC Plan).

MassHealth CommonHealth provides benefits to disabled adults, both non-working and working, and children who are not eligible for MassHealth Standard. There is no income limit for CommonHealth; however, non-working disabled adults are required to meet a one-time deductible before becoming eligible. CommonHealth members whose gross family income is greater than 200% FPL (approximately) are required to pay a monthly premium. The benefit package is very similar to that provided to members under Standard, except that it is generally provided on a fee-for-service basis.

MassHealth Family Assistance provides benefits to children who are not eligible for Standard or CommonHealth, whose gross family income is greater than 150% FPL, but not more than 200% FPL. These children receive premium assistance toward qualifying employer-sponsored health insurance, when available. In certain cases, the Division also provides coverage for copayments related to well-baby/well-child visits and other copayments/deductibles after the out-of-pocket expenses for the children have exceeded 5% of the family's gross income. If there is no access to qualifying health insurance, children receive services through one of the Division's managed-care plans. The benefits are similar to those provided under Standard, with the exception of non-emergency transportation and long-term-care services. Monthly premiums are assessed at $10 per child, with a maximum payment of $30 per family.

Family Assistance also provides premium assistance to certain adults who work for participating employers and have family incomes at or below 200% of the FPL. In addition to making premium assistance payments, the Division makes an Insurance Partnership payment to the participating employer to assist in the cost of the health insurance for low-income employees and their families.

As of April 1, 2001, persons that are HIV positive with gross family incomes at or below 200% of the FPL are also eligible to receive benefits under Family Assistance.

MassHealth Basic provides benefits to adults who are long-term unemployed and whose gross family income is no more than 133% FPL. Basic benefits are provided through managed-care plans for persons who do not have private health insurance. The benefit package does not include non-emergency transportation or long-term-care services. Persons who are otherwise eligible for Basic, but who have health insurance, receive MassHealth Buy-In. Through Buy-In, the Division pays for all or most of the cost of the member's private health insurance.

MassHealth Limited provides emergency services, including labor and delivery, to undocumented aliens, who would otherwise be eligible for MassHealth Standard but for their immigration status.

MassHealth Prenatal provides time-limited prenatal services to pregnant women who self-declare gross family income that is at or below 200% of the federal poverty level. Once income is verified, these women become eligible for MassHealth Standard.

MassHealth Meets the Strategic Objectives of the 1115 Demonstration Project

The Division has successfully met its strategic objectives of the Demonstration Project. These objectives and a summary of the success of Massachusetts in achieving each objective follow.

Expand access to health coverage for low-income residents:

Both state and national surveys have found that MassHealth has been a significant factor in the reduction in the number of uninsured in Massachusetts. Results from the Massachusetts Division of Health Care Finance and Policy's *2000 Health Insurance Status of Massachusetts Residents Survey* show a 2.3 percentage point decline in the number of uninsured in Massachusetts from 8.2% of the population in 1998 to 5.9% in the spring of 2000. The rate of uninsured declined in every age-category, and for children less than 18 years of age, the rate of uninsurance dropped from 5.8% in 1998 to 2.8% in 2000.

Massachusetts's success in enrolling children, as a result of both the 1115 Demonstration expansions and the State's Children's Health Insurance Plan (SCHIP) implementation, is evidenced by our leadership among states in covering low-income children. Massachusetts ranks second best among all states in its average monthly progress in enrolling eligible children for health insurance coverage under SCHIP and Medicaid combined. The Children's Defense Fund calculated this ranking based on setting a target number of uninsured children for each state (those uninsured children in the state at or below 200% of FPL), and then calculating the states' average monthly rates of progress toward covering the target number. States were then ranked from highest to lowest by their monthly progress rates. [3]

The Urban Institute's National Survey of American Families (NSAF) also points to the success that Massachusetts's 1115 Demonstration and SCHIP is having in reducing the number of uninsured in the state. Massachusetts is one of thirteen states participating in the NSAF as part of the Urban Institute's *Assessing the New Federalism* initiative. Among the areas being surveyed are changes in health-care coverage for children and adults within different income groups. As described in the following paragraphs and in Table 2, the uninsurance rate in Massachusetts dropped significantly from 1997 to 1999.

NSAF found that there were statistically significant reductions in the Massachusetts uninsurance rate for all children, with the uninsured dropping from 6.2% in 1997 to 3.4% in 1999. For low-income children in Massachusetts, NSAF found that the rate of uninsurance dropped over 7 percentage points, from 13.8% in 1997 to 6.5% in 1999.

Results from the 1999 NSAF survey also show a dramatic reduction in uninsurance in adults, with rates dropping from 11.3% in 1997 to 8.3% in 1999. NSAF found that the rate of uninsured low-income adults in Massachusetts also dropped, declining from 30% in 1997 to 19% in 1999. NSAF speculates that this reduction reflects the expansion in Medicaid coverage of low-income adults since implementation of the Demonstration. Among the factors setting Massachusetts apart from other states in reducing the number of uninsured low-income adults cited by NSAF are MassHealth's enrollment of both parents and non-parents, and the subsidy for employer-sponsored insurance for some low-income adults.

[3] "All Over the Map – A Progress Report on the State Children's Health Insurance Program" Children's Defense Fund, Washington, D.C. July, 2000

Table 2. Uninsurance Rate in Massachusetts, NSAF Survey

Population	**1997**	**1999**	**% Point Decline**
All Children	6.2%	3.4%	2.8%
Low-income Children	**13.8%**	**6.5%**	**7.3%**
All Adults	11.3%	8.3%	3.0%
Low-income Adults	**30.0%**	**19.0%**	**11.0%**

Improve the efficiency of the eligibility determination process:

Under its 1115 Demonstration, Massachusetts simplified the application process for the MassHealth program. By creating a single, seamless program and by simplifying the eligibility determination process for both our applicants and staff, the Division has made the MassHealth application and approval process easier. Generally, applications are processed within 3 to 5 days through the use of our automated eligibility system, MA21. The MA21 system ensures that an applicant will be determined eligible for the richest benefit for which he or she is eligible.

In addition to creating improved systems for eligibility determination, the Demonstration removed the traditional asset rules. These rules placed a significant burden on both the applicant and staff in determining eligibility. Their removal added to the simplification of the eligibility process.

Create a successful marketing and outreach campaign:

The Division has made a concerted effort to raise the public's awareness of the MassHealth program and to ensure that all eligible residents apply for the program. To do this, the Division has used a wide range of marketing and outreach strategies to reach targeted audiences. Through one initiative, known as the "mini-grants," the Division provides seed money to community-based organizations engaged in health-access activities to support their work in marketing the MassHealth program and assisting our applicants and members. In addition, we collaborate with other state agencies and local communities, target outreach to specific ethnic groups, engage in school-based outreach activities, and expend considerable efforts toward providers and stakeholders in the medical community. The Division also pursues an aggressive media and promotional agenda to reach those who may be eligible for MassHealth. The Division makes a particular effort to ensure that our outreach materials are culturally and linguistically appropriate. We have developed a number of member education pieces, brochures, posters and promotional materials, including pens, magnets, frisbees, water cups, and Rolodex cards. Mass media has been used to target specific groups as well as to encourage enrollment in the Insurance Partnership.

Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income residents:

Through its MassHealth Demonstration, the Division is able to provide coverage to individuals and families well beyond those traditionally eligible for Medicaid. The Demonstration, which applies to persons under the age of 65, allows MassHealth to provide coverage to children with income levels up to 200% of the FPL, their parents with incomes to 133% of the FPL, disabled adults and children of any income level, the long-term unemployed with incomes up to 133% of the FPL, and to employees with incomes up to 200% of the FPL who work for a qualified employer through our innovative Insurance Partnership program. In addition, on April 1, 2001, the Division further expanded its MassHealth coverage to provide benefits to HIV-positive individuals with incomes at or below 200% of the FPL.

Through its Insurance Partnership and premium assistance programs, the Division has supported employer purchase of health insurance. This innovative design is one of the few successful programs of its kind in the nation. The Division provides premium assistance towards employer-sponsored health insurance that meets a basic benefit level and to which the employer contributes at least 50% of the cost. In addition to providing benefits to those who are eligible for MassHealth, the programs, at no extra cost to the Division, make employer-sponsored health insurance available to all family members, even if they are not eligible for MassHealth.

Over 10,000 people currently benefit from this premium assistance program, and the program is growing at a rate of over 500 new members per month. The 2000-plus qualified small employers that participate in our program receive an incentive payment toward the cost of their low-income employees' health insurance. Two-thirds of the participating employers began offering insurance to their employees when they enrolled in the Insurance Partnership. Likewise, two thirds of the persons receiving premium assistance benefits from the Division began purchasing insurance through their employers upon enrollment in MassHealth.

Continued quality improvement through managed care:

Under the Demonstration Project, Massachusetts requires most MassHealth members to enroll in managed care. MassHealth's managed care program gives members a choice of enrolling in either the Division's Primary Care Clinician (PCC) Plan or one of a number of contracted comprehensive Managed Care Organizations (MCOs). Members who enroll in the PCC Plan receive behavioral health services through a behavioral health vendor under contract with the Division. Both the PCC Plan and the Division's contracted MCOs continue to implement extensive quality-improvement activities in order to yield improvements in access to care and quality of care for MassHealth members. Key

components of the quality-improvement initiatives for the PCC Plan and MCO Program include routine measurement activities such as Health Employer Data Information Set (HEDIS) measurement and Member Satisfaction Surveys; Network Management activities including provider profiling; and annual implementation of Quality Improvement Projects. The Division's health plans have generally succeeded in obtaining high levels of performance. For example, for the HEDIS 2000 (Reporting Year 1999), the MassHealth mean and median score exceeded the HEDIS national commercial rate for all 5 measures for which such comparisons were available.

2. Special Terms and Conditions

Massachusetts believes it is substantially in compliance with all waiver Special Terms and Conditions. Because of their length, the Terms and Conditions are not reprinted here but are attached to this document as Attachment 1. The Commonwealth's demonstration of compliance is presented in the same order and using the same numbering scheme as found in the revised Terms and Conditions, dated August 1, 1995. References to the Protocol Document are to the approved version dated January 19, 2001, unless otherwise noted.

1. State Authorizing Legislation. State law enabling implementation of the MassHealth Demonstration (except for the Insurance Partnership) was enacted in July 1996, as Chapter 203 of the Acts and Resolves of 1996 – *An Act Providing Improved Access to Health Care*. State law enabling implementation of the Insurance Partnership (formerly known as the Insurance Reimbursement Program) was enacted in July 1997 as Chapter 47 of the Acts and Resolves of 1997 – *An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth*. State law enabling the MassHealth children's expansion was enacted in November 1997 as Chapter 170 of the Acts and Resolves of 1997 – *An Act Expanding Access to Quality Health Care for Working Families, Children and Senior Citizens in the Commonwealth*. Lastly, state law authorizing the HIV expansion was enacted November 16, 1999.

2. a-d. Compliance with non-waived provisions of Federal Medicaid law. The Division has complied with all requirements of the Medicaid program that have not been expressly waived for MassHealth, including changes to the federal law (e.g. BBA provisions regarding DSH).

3. Pre-Implementation Workplan. The Division submitted a timely pre-implementation workplan that was approved by CMS.

4. Protocol Document. The operational Protocol Document was submitted with all required chapters and was approved by CMS. Subsequent revisions to the Protocol Document have also been submitted to and approved by CMS.

5. 1915(b) waiver incorporated into 1115 Demonstration. Upon enactment of the state authorizing legislation, the Commonwealth's 1915(b) waiver was incorporated into the 1115 MassHealth waiver.

6. Phase-out Plan. The Commonwealth currently has no plans to phase-out the MassHealth program and, instead, seeks an extension of the current

Demonstration. Therefore, this Term and Condition is not applicable at this time.

7. BPHC/CPHC. As part of the Demonstration, the Secretary of Health and Human Services waived the Upper Payment Limits for capitation contracts within contracts between the Division and "the managed-care delivery systems operated by Boston City Hospital and Cambridge Hospital" in order to allow those systems to provide managed Medicaid coverage under the MassHealth program. The managed care programs, Boston Medical Center HealthNet Plan and Network Health, are run through the Boston Public Health Commission (BPHC) and the Cambridge Public Health Commission (CPHC), respectively.

   Section 3.2.2.4 of the Protocol Document explains how HealthNet and Network Health participate in the Demonstration. The Commonwealth has pre-paid health plan contracts with both BPHC and CPHC that allow for their participation as managed care plans for MassHealth. As such, HealthNet and Network Health must meet all requirements contained in the MCO contract.

8. Encounter Data. The Division requires that its managed care plans collect 100% encounter data. In addition, the Division developed and implemented plans for the collection, reporting, and analysis of encounter data from the PCC Plan, the PCC's Behavioral Health Plan and MCOs for all MassHealth populations and a process for validating such data collection. See Section 7.1 of the Protocol Document.

9. Encounter Data. The Division annually collects and forwards encounter data to CMS on selected clinical indicators. Information is submitted through the Minimum Data Set for the MCOs and the PCC Plan's Behavioral Health vendor. Information is submitted quarterly through MSIS for the PCC Plan and the fee-for-service wrap-around claims for the MCOs. In addition, the Division submits reports on its HEDIS initiative and a Summary Analysis of Clinical Indicators to CMS annually. While some clinical indicators are calculated directly from encounter data, some are difficult to collect through encounter data and instead are only available when collected through administrative data.

   For example, the Division has been unable to analyze prenatal care through encounter data, where the necessary information is not found on claims. The Division is able to collect postpartum care follow-up rates and the percent of women starting care during the first trimester as part of its HEDIS initiative. These measures are being collected in 2001. The Division uses HEDIS specifications and looks at postpartum care delivered between 21 and 56 days after delivery. The Division has revised its Notification of Birth Form (NOB) to capture birth weight of newborns

born to mothers enrolled in managed care. The PCC Plan collected birth weight data on the HEDIS 2001 perinatal samples to verify the data submitted on the PCC Plan NOBs. Once verified, the data will be analyzed to measure rates of low and very low birth weight. Infant mortality and ethnicity are not available through encounter data.

The Division has been able to collect immunization rates through the HEDIS initiative. Immunization rates were last collected in 2000.

Pediatric asthma information has been collected through encounter data. The Division last submitted information in July 1999 and will again submit this information in July 2001.

The Division collected information regarding eye examinations for people with diabetes through HEDIS in 1998. This measure has since been removed by NCQA from the HEDIS set and replaced in 1999 with the Comprehensive Diabetes Care Measure. Since 1999 was a "first" or "test" year for the measure, it was optional for plans to collect. The PCC Plan and one MCO collected the measure in 1999. The MCO program collected data on comprehensive diabetes care as part of its CY2000 clinical topic review.

10. Encounter Data.
    a. The Division engaged the MEDSTAT Group prior to the implementation of the Demonstration to study the completeness and accuracy of encounter data collected by the MCOs with which the Division contracted in 1997. See Section 7.3.1 of the Protocol Document.

    b. The Division has engaged the MEDSTAT Group to conduct annual validation studies on the completeness and accuracy of the encounter data collection of the MCOs.

11. Encounter Data. At the time of implementation of the Demonstration, the Division contracted with two new managed care plans – BMC and CPHC. Section 7.3.2 of the Protocol Document required annual validation testing to determine the completeness and accuracy of the encounter data of the pre-paid health plans. The Division has shown that all of its managed care plans, including BMC and CPHC, meet the 90% completeness and accuracy test for encounter data.

12. Utilization Data/IP program. The Division has not yet collected utilization data through employee surveys for members receiving premium assistance payments (subsidies). As described in Section 7.5 of the Protocol Document, the approach and goals regarding the collection of utilization data for services received under the Premium Assistance Plan are in discussion. Since the Premium Assistance Plan and the Insurance

Partnership is only recently fully implemented (January 2000) and the sample size would be small, the Division is still considering a reasonable approach to collect this data.

13. Encounter Data. All encounter data maintained at the MCOs can be linked with the eligibility files maintained at the Division.

14. Quality Assurance Monitoring Plan. Chapter Six of the Protocol Document describes the Division's overall quality assurance monitoring plan for each component of MassHealth, including the monitoring of mental health and substance abuse treatment. The Division has provided updates on quality assurance monitoring activities in the 1115 Demonstration annual reports.

15. Member Satisfaction Surveys.
    a. The Division conducts an annual MassHealth Member Survey on a statistically valid sample of members in the PCC Plan and contracted MCOs and provides CMS with the results of the survey in the form of a written report. See member satisfaction surveys for 1998-2000. A copy of the 1999-2000 Survey is attached as Attachment 2.

    b. To date, all member satisfaction surveys reveal that members have been satisfied with the managed care plans and there has been no need for a quality improvement process.

16. MCO Grievance and Appeals. The Division requires its MCOs to report semi-annually on the number and types of grievances and appeals filed by or on behalf of MassHealth enrollees as well as how such grievance and appeals were resolved. The Division's annual reports to CMS have included a summary of the MCO program appeals.

17. Internal and External Audits. The Division has developed internal and external audits to monitor the performance of its managed care plans under MassHealth. As described in Section 3.2.2.2.5, the Commonwealth monitors and evaluates the financial solvency, stability and expenditures of its MCOs annually and throughout the year through the collection and analysis of financial reports and insurance policies. The Commonwealth also conducts an independent external review of the MCOs. This review is described in Section 6.5 of the Protocol Document.

18. Federal Audit Requirements. The Division meets all applicable Federal periodic medical audit requirements for contracted managed care plans participating in MassHealth and requires that the MCOs satisfy the access and solvency standards established by CMS pursuant to 1903(m)(1)(A) of the Social Security Act as well as the requirements of 1902(w) of the Social Security Act regarding advanced directives.

19. Eligibility Description and Plans in Protocol Document

a. Chapter 2 of the Protocol Document includes a description of the centralized and simplified determination process. For each expansion to our MassHealth program and change to our 1115 Demonstration, the Protocol Document has been updated to include a description of MassHealth eligibles; revised applications; a description of the role and placement of outstationed workers; a description of the eligibility determination process and its coordination with the enrollment process; and a description of verification requirements. The Medical Security Plan (MSP), which provides health coverage to those receiving unemployment benefits, is described in Section 3.8 of the Protocol Document. It continues to be operated by the Department of Employment and Training, and its agent, Blue Cross and Blue Shield of Massachusetts.

b. Although the Division had initially anticipated completely eliminating spenddown under the Demonstration, the Division retained a modified spenddown approach. Under the modified approach, the non-working disabled population that has incomes over 133% of the FPL is required to meet a one-time deductible. This rule is described in Section 2.1.4.8 of the Protocol Document. The conversion process for transitioning to CommonHealth those individuals who were eligible for MassHealth prior to the implementation of the Demonstration and who would otherwise have become ineligible because of the spenddown rule is described in Section 2.2.3.3 of the Protocol Document.

c. As described in Section 2.2.3.3 of the Protocol Document, the Division developed a process for monitoring those persons who became ineligible for a MassHealth program due to the changes under the Demonstration. Families had their eligibility protected for a one-year period. At their next redetermination, if they were no longer eligible for MassHealth, children were referred to the state-funded Children's Medical Security Plan (CMSP).

d. The Division's automated eligibility system, MA21, redetermines a member's eligibility at any time there is a change to the household's information. MA21 cascades through the Decision Trees (Attachment 2.3 to the Protocol Document) and places the member in the most generous coverage type for which he or she is eligible.

e. The implementation of the 1115 Demonstration and further MassHealth expansions under the Demonstration did not lead to the termination of the CMSP but it has reduced the number of children eligible for that state-funded program (run by the Massachusetts Department of Public Health). The Protocol Document, at Section 2.2.3.3, describes the process for transitioning children formerly eligible for CMSP into MassHealth.

f. Chapter 11 of the Protocol Document describes the Insurance Partnership program, including the Division's process for ensuring that plans meet the Basic Benefit Level. The Division does not provide the originally envisioned tax credits to employers under the Insurance Partnership; instead, employers receive an incentive payment each month which helps them pay for the health insurance that they contribute towards for their employees who receive Premium Assistance from MassHealth.

g. The Division's Eligibility Determination Process is described in Section 2.2 of the Protocol Document. Section 2.2.1 describes the application process. The Division generally determines eligibility within 15 calendar days of receipt of the complete MBR. See Section 2.2.3.1 of the Protocol Document. In practice, most MBRs are processed within 5 days of receipt.

   The Division has directed significant resources towards out-stationed workers. Currently, 27 outreach workers rotate between 136 hospitals, community health centers, and emergency service providers. The outreach workers' primary functions include providing education, training and support to provider staff and others on the application process and the MassHealth program requirements, assisting applicants and provider staff in completing applications (MBRs), and screening and coding MBRs to ensure expedited processing of the MBRs at the Division's Central Processing Unit. See Section 2.3 of the Protocol Document.

20. Protected members. Section 2.2.3.3 describes the process for protecting non-disabled members who would lose eligibility due to elimination of the spend-down portion of the Medically Needy Program. Those members (who had family incomes above 133% of the FPL or who were otherwise ineligible under the new eligibility rules) were grandfathered with coverage for one year from the deductible end date.

21. MEQC. Section 2.5 of the Protocol Document included plans for the Department of Transitional Assistance (DTA, formerly the Department of

Public Welfare) to provide the post-audit review procedures for the entire MassHealth population. Following the first year of the Demonstration, the Division created its own Quality Control unit and subsequently has proposed new project ideas to CMS for approval. Project ideas have maintained the goal to ensure that MassHealth members meet eligibility requirements and that there is adequate monitoring of the administration of the eligibility determination processes under MassHealth. In addition, projects have included a review of the Insurance Partnership program. The Division has worked with CMS to update this section of the Protocol Document. The newly revised section 2.5 was submitted to CMS on 6/28/01 and is attached here as Attachment 3.

22. Member Enrollment. Chapter 4 of the Protocol Document details the Division's Member Enrollment process. The Division uses an Enrollment Broker to educate and enroll all appropriate MassHealth members in a health plan. The Health Benefit Advisors (HBAs) are employees of the Enrollment Broker.

    a. HBAs are responsible for enrolling MassHealth members in a managed care plan. The process used by the HBAs to enroll MassHealth members in a managed care plan is described in Chapter 4 of the Protocol Document. For example, Section 4.2.2 provides a description of the Enrollment Process for the MassHealth Standard population. The same process is used for MassHealth Basic members and those MassHealth Family Assistance members who are enrolled in a managed care plan. As described in Section 4.2.2.2.3 of the Protocol Document, upon enrollment of a member with a PCC or an MCO, the system automatically sends confirmation information to the PCC or MCO. A confirmation letter and Member Services Guide are sent to the MassHealth member.

    The HBAs do not inform members eligible for premium assistance about the amount of the subsidy or how to access it. This function is done instead by the Division's Health Insurance Identification contractor or one of the IP administrative entities. See Section 2.2.2.2 and Section 11.4.2. The Division makes the final eligibility decision and sends a notice to the member regarding the amount of the premium assistance payment. In addition, the HBAs do not determine eligibility for any MassHealth program – eligibility determinations are done by MA21, the Division's automated eligibility system, once data is entered into the system by Division employees.

    As described in Section 4.3.1 of the Protocol Document, all persons eligible to receive Emergency Aid for the Elderly, Disabled, and Children (EAEDC) health benefits are eligible for Basic coverage.

MassHealth Basic members receive an enrollment package. The enrollment process is the same as for the MassHealth Standard population.

In addition to enrolling eligible members in a managed care plan, the Enrollment Broker also serves as the MassHealth Customer Service Center and operates a toll-free customer service call center. See Section 4.5 of the Protocol Document.

b. Section 4.6 of the Protocol Document describes how enrollments to participating health plans are tracked and recorded. This section also describes how the Division monitors assignment rates.

c. As described in Section 4.2.2.3, Standard members who do not choose a health plan within the fourteen-calendar day time limit are assigned to a health plan. The Division has created an assignment methodology that takes into account the geographic location of the MCO and PCC plan providers relative to the member's residence. The Division assigns members based on the rate at which a given health plan is selected in a given service area compared to each of the other available plans. The algorithm is explained fully in Section 4.2.2.3.2.1 of the Protocol Document. Standard members can subsequently transfer to another health plan within their geographic service area at any time for any reason. (This is also true for all MassHealth members who are enrolled in managed care – including Family Assistance, Basic, and those CommonHealth members who voluntarily enroll.)

d. As described in Section 4.3.2.3, Basic members who do not choose a health plan within the fourteen calendar day time limit will be assigned to a health plan. Basic members are assigned using the same methodology and algorithm that is used to assign Standard members. Basic members can subsequently transfer to another health plan within their geographic service area at any time for any reason.

e. The Division tracks automatic (assigned) and voluntary enrollment rates. See Section 4.6.3 of the Protocol Document. The Division submits a monthly enrollment report to the CMS project officer.

23. MCB. Section 2.2.4 of the Protocol Document details the Division's coordination with the Massachusetts Commission for the Blind to ensure that their eligible constituents are enrolled in MassHealth. The MCB provides outreach to individuals and families who are potentially eligible for MassHealth, assists in the application process, and forwards the MBR to the Division. The Division then inputs the information into MA21 so

that the Division can establish and update MassHealth benefits. See Section 2.2.4.2.1 of the Protocol Document.

The Division has also worked with the MCB on the enrollment process for our members with sight impairments. All enrollment materials are printed in large print or are available on audiocassette or in Braille. See Section 4.2.2.5.1 of the Protocol Document.

As the single state agency for the Medicaid program, the Division has assumed responsibility for all financial reporting to CMS. See Section 9.8 of the Protocol Document. The Division and MCB have entered into an Interagency Service Agreement (ISA) to formalize each agency's responsibilities.

24. Managing beneficiary enrollments and the marketing process.
a. Section 4.7.3 of the Protocol Document describes the performance measures for the HBAs. Call monitoring is used by the Enrollment Broker to measure the comprehensiveness of the HBA enrollment presentations as well as their interactions with members.

b. Section 4.8 of the Protocol Document details the allowable marketing strategies for the MCOs and PCC plan.

c. Section 2.4 of the Protocol Document describes the training curriculum offered for eligibility and outstationed workers employed by the Division of Medical Assistance at the time of waiver implementation. The Division offers continuing Health Care Reform and MA21 training for: new eligibility workers; refresher sessions targeting specific areas; and introductory sessions accompanying the roll-out of any new Health Care Reform initiative. In addition, the Division now has in-house trainers located in each of the MECs.

d. MSP eligibility workers continue to be trained by the Department of Employment and Training (DET). The Division has entered into an ISA with DET regarding the MSP program. DET has contracted with Blue Cross and Blue Shield of Massachusetts to operate the MSP program. See Attachment 6.1 of the Protocol Document.

25. HBA Training. Section 4.7 of the Protocol Document describes the HBA Training Process in detail, including a description of the training process; an implementation plan for the trainings, and a description of the training curriculum. As described above, the MSP program operates through Blue Cross and Blue Shield of Massachusetts. The HBAs play no role in that program.

26. Federal Financial Participation.
    a. The Division provides quarterly expenditure reports using the HCFA 64 to separately report expenditures for those receiving services under the Medicaid program and those participating in MassHealth under the 1115 Demonstration.

    b. The Division submits the HCFA 64 according to standard Medicaid reporting requirements and submits quarterly supplemental schedules that reconcile to the reported HCFA 64. Currently, the Division uses the HCFA 64 to report DSH payments. The Division is working towards reporting DSH separately by waiver year, and hopes to be able to do so by the next reporting period.

    c. The Division had provided the actual caseloads for each of the MassHealth programs, and by appropriate groups within each programs to the regional office and in the Budget Neutrality Reports.

    d. This provision is not applicable at this time.

27. Standard Medicaid Funding Process. The Division follows the standard Medicaid funding process for the Demonstration. The Division estimates matchable MassHealth expenditures on the HCFA-37 and submits the HCFA 64 to CMS.

28. Unduplicated Costs. The Division assures CMS that all costs claimed for Federal financial participation under the Demonstration are not already being reimbursed through existing statewide or department cost allocation plans.

29. This Term places no specific responsibility on the Commonwealth.

30. Supportive Documentation. Section 9.5 of the Protocol Document details the types of supportive documentation available that provide the details of the Division's administrative and programmatic expenditures.

31. IP Definitions. The Division complies with CMS's definition of "continuing employer-provided health insurance" and "improved employer-provided health insurance". The Division also treats self-employed individuals as required by CMS under this term and condition.

32. The Division has not yet requested that CMS extend FFP for continuing or improved employer-provided health insurance.

33. IP Employer Survey. Section 7.6 of the Protocol Document, as submitted on 6/28/01, details the Division's plans for data collection and employer

surveys. Instead of conducting its own survey, the Division will be analyzing data collected by other surveys, including a survey to be conducted by CMS's independent evaluator, HER, and a Massachusetts state-wide survey being conducted in conjunction with the Commonwealth's HRSA grant. A copy of this revised Section 7.6 is attached as Attachment 4.

34. Certified Public Expenditures. Annual financial statements of public hospitals, which incur certified public expenditures (CPE) eligible for FFP, are submitted annually to, and reviewed by, the Commonwealth.

35. CMS Authority to Verify IP Information. The Division assures that CMS has authority to verify all information necessary to demonstrate that an employer met all requirements to receive a federally matchable incentive payment. As discussed previously, the Division did not implement the Insurance Partnership using tax credits. Instead, the Division makes monthly incentive payments to participating employers.

36. Availability of Records for CMS's Review. All records used in the preparation and submission of the HCFA 64 and HCFA 37 reports have been and continue to be available for CMS to review.

37. Free Care Pool/Reserve Pool Mechanism. In Section 9.6 of the Protocol Document, the Division details the free care pool. Uncompensated care provided by acute hospitals and community health centers is reimbursed from the Commonwealth's Uncompensated Care Pool (the Pool). The Commonwealth did not employ an additional "reserve mechanism" to reimburse free care because the availability of funding in the Pool has been sufficient to maintain and increase levels of reimbursements to the hospitals and community health centers. Since the implementation of the Demonstration, the uncompensated care pool has been able to significantly increase reimbursement to those hospitals and community health centers with allowable unreimbursed costs. In SFY96, reimbursement from the Pool was at 67% of costs. In SFY97 that rate increased to 76%. For SFY98 and SFY99, the Pool was able to reimburse at 100% of cost. In SFY00, 98% of costs were reimbursed.

38. Counting Conventions. Section 9.7 of the Protocol Document, as submitted on 6/28/01, describes the counting convention for Demonstration and non-Demonstration eligibles. A copy of the revised Section 9.7 is attached as Attachment 5.

39. Performance Based Contracts. The Division has not implemented the provision of its waiver that allows for the payment to PCCs under performance-based contracts.

40. Family Planning. Section 3.2.2.2.2.3 of the Protocol Document describes how members may confidentially and without restriction access family planning services.

41. RFP Process For MCOs. The Division has used a Request for Proposal (RFP) process to select its managed care plans. CMS Region One has approved all managed care contracts.

42. CMS Approval of Rates. The Division has submitted to CMS for approval all capitation rates and the fee-for-service upper payment limits from which they are derived.

43. Under this term, the Division is not required to comply with Federal coverage and reimbursement requirements for rural health centers and federally qualified health centers for the Medical Security Plan, MassHealth Basic (formerly the New State Benefit Plan), MassHealth CommonHealth and the Insurance Partnership (formerly the Insurance Reimbursement Program).

44. MCO Requirements

a-c. The Commonwealth has provided CMS Region One with copies of contracts for review and approval.

d. Section 3.2.2.2.6 of the Protocol Document describes the cultural competency requirements that are placed on the MCOs through their contracts. Section 4.9 of the Protocol Document provides further details on the Division's cultural competency activities. The Division's assurance of compliance with the access requirements of Attachment B to the special terms and conditions is provided on page 25 of this document.

e. Section 3.2.2.2.5.2 of the Protocol Document details the Division's requirements for MCOs to maintain insurance policies to ensure adequate protection of enrollees against the risk of the financial liability or insolvency of the plan. MCOs are required to: maintain insurance, meet the Division's insolvency requirements and submit annual copies of audited financial statements to the Division. In addition, the MCO contracts include protections for members related to prohibitions on balanced billing.

f. Copies of subcontracts or individual provider agreements with MCOs are available to CMS, upon request.

g. Section 4.8.1 of the Protocol Document describes the allowed marketing and outreach strategies for MCOs. Section 4.8.1.2 specifically delineates prohibited marketing and enrollment activities.

45. Procurement Review. The Division has provided CMS with procurement and final contracts to review.

46. Disclosure Requirements. The Commonwealth assures CMS that it complies with the usual Medicaid disclosure requirements at 42 CFR Part 455, Subpart B.

47. Coordination of MH/SA Services. Section 3.2.2.3.3 of the Protocol Document details the Division's approach to coordinating mental health and substance abuse services for enrolled individuals who receive services from multiple Commonwealth agencies.

48. Diversionary Services. Section 3.2.2.3.3.2 of the Protocol Document details the Division's plan for monitoring the Behavioral Health Plan contractor's administration of diversionary services.

49. School Based Health Services. Sections 3.2.2.1.2.2 and 3.2.2.2.2.1 of the Protocol Document detail how MassHealth providers coordinate with school-based health services.

50. PCC Service Areas. Section 4.2.2.3.2 of the Protocol Document details the Division's Geographic Service Area. Section 4.2.2.4 of the Protocol Document details how and when beneficiaries may enroll with a PCC not located in their geographic area.

51. FQHCs. The Commonwealth has not implemented selective contracting with federally qualified health centers (FQHCs). As Section 3.2.2.1.4.5 of the Protocol Document explains, FQHCs currently participate in the MassHealth program as providers in the PCC Plan, reimbursed on a fee-for-service basis, or as providers to one of the Division's contracted MCOs.

52. Timely notice. The Division has complied with the Commonwealth's administrative procedure law in publishing adequate and timely notice of changes made to the MassHealth program. These procedures are documented in Section 10.1 of the Protocol Document.

53. MCO Risk Band. As required by this Term and Condition, the Division developed capitation rates for MassHealth Basic (formerly known as the New State Benefit Plan) members enrolled in MCOs. The contractor-specific capitation rates were developed by the Division through its independent actuaries, William M. Mercer, Inc. for the new MCO Rating Category for MassHealth Basic members. Risk bands were created for the first three years of the Demonstration. The methodology for the capitation rates and the risk bands were shared with CMS and made part of the Protocol Document (at Section 3.3.2.2). After three years, there

were no longer risk corridors for MassHealth Basic. The Division pays the MCOs monthly capitation rates that comply with the federal upper payment limit requirements of 42 CFR 447.361, except for BPHC (Boston Medical Center HealthNet Plan) and CPHC (Network Health) which may receive payments that exceed the upper payment limit under the Demonstration. MCOs are now provided with the option to purchase stop-loss insurance.

54. EPSDT. The Division complies with EPSDT requirements and submits its reports as required by this term and condition and section 2700.4 of Medicaid Manual.

55. Contract Provisions. All contracts and subcontracts for services related to MassHealth are required to provide that the Division and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records of such contractors and subcontractors.

56. Progress Reports. Following the approval of the 1115 Demonstration and through January 1998, the Division provided CMS with monthly progress reports. The Division now submits quarterly reports to CMS.

57. Annual Reports. The Division has submitted draft and final annual reports to CMS documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties in a timely manner.

58. DSH Payments. The Division's procedures for assisting hospitals to distinguish members who would otherwise be eligible for Medicaid in absence of the Demonstration from all other individuals are described in Section 9.7.4.7.

59. Demonstration Modifications. The Division has requested modifications to the Demonstration by submitting revisions to the protocol for CMS approval.

60. MMIS. Prior to enrolling beneficiaries into the new MassHealth programs, the Division provided evidence to CMS that a management information system is in place to meet the minimum standards of performance.

61. Final draft report. This term is not applicable at this time.

62. Suspension or termination of project. This term is not applicable at this time.

63. Independent Evaluation. Health Economics Resources (HER) has been chosen by CMS as an independent contractor to evaluate the Demonstration. The Division has fully cooperated with HER as it evaluates the Demonstration.

64. Regional Office. The Division has sent the Regional Office copies of all letters, documents and other materials sent to the CMS project officer.

65. Continuation Applications. The Division has submitted continuation applications to CMS for each "award year."

Attachments to Terms and Conditions

A. Monitoring Budget Neutrality. The Division has tracked and reported its performance with respect to Budget Neutrality in accordance with the instructions provided in Attachment A of the special terms and conditions. For more detail regarding Budget Neutrality, see Section 6 below.

B. Access Standards, Quality Monitoring and Financial Monitoring of Managed Care Plans. The Division meets CMS's requirements for access standards, quality monitoring and fiscal monitoring of managed care plans. The Division's contracts with its managed care providers requires that the contractors meet the Division's access standards, quality assurance requirements, provider monitoring requirements and financial monitoring requirements.

   Chapter 6 of the Protocol Document details the Division's quality assurance monitoring plan. All managed care plan contracts require that the MCOs and the PCC Plan's Behavioral Health vendor meet, at a minimum, the access requirements of Attachment B. For example, as described in Section 4.2.2.3.2 of the Protocol Document, each MCO contract has proximity requirements that each enrollee have a choice of at least two primary care providers within a 15-mile radius and/or 30-minute travel time. In Section 3.2.2.3.2.2 of the Protocol Document, the PCC Plan's Behavioral Health vendor is responsible for ensuring that members have access to all covered services with a maximum of 30 minutes travel time. In addition, the contract requires that emergency care be provided immediately; urgent care be provided within 48 hours; and non-urgent care be provided within 10 working days.

C. Outline for Operational Protocol. The Division developed its operational protocol in accordance with the outline provided by

CMS in Attachment C. CMS has approved the Division's original Protocol Document and subsequent revisions.

3. Evidence of Beneficiary Satisfaction

The Division conducts an annual MassHealth Member Survey for the purpose of eliciting member feedback in a number of areas including availability and access to services, utilization and experience with health services, as well as member satisfaction with the services delivered by their health plan or provider. To date, the Division has completed three annual surveys – 1997-1998 Member Survey, 1998-1999 Member Survey, and 1999-2000 Survey. The results of the first two surveys were included as part of the Division's1115 annual reports for the years 1998 and 1999. As mentioned above, the 1999-2000 survey is attached as Attachment 2. The Division has also provided information regarding complaints, grievances and appeals in its annual reports.

4. Documentation of Adequacy and Effectiveness of the Service Delivery System

The Division's provider capacity assessment and capability and analysis continues to show that there is access statewide for members to choose PCCs. The Division's Primary Care Clinician Plan (PCC Plan) issues a Capacity Report every six months to identify potential access issues for PCC Plan members. The report provides a snapshot of MassHealth enrollment and contains information on the PCC Plan, MCO Program, and unenrolled populations by service area. Most recently, in March 2001, the PCC Plan issued a Capacity Report, providing information on a city and town basis to compare PCC practices to MassHealth managed care membership. Currently there are over 1900 PCC sites, 88% of which have open slots.

Section 7 below further discusses the Division's compliance with CMS's access and adequacy requirements.

5. Quality

As discussed under specific terms and conditions above, the Division employs a variety of methods to monitor the quality of its health plans. For example, the Division incorporates specific quality standards into its MCO contracts and requires annual reporting on HEDIS measures. Quality endeavors specific to the PCC Plan, its Behavioral Health vendor and the capitated MCOs, as well as the CommonHealth program have been provided annually to CMS as part of the 1115 annual report.

6. Budget Neutrality

As required by the special terms and conditions to the Commonwealth's Section 1115 Demonstration, the Commonwealth's expansion program is projected to remain budget neutral throughout the length of the initial 5-year expansion. The agreed-upon method for determining budget neutrality under the Demonstration uses a per-capita cost method, with targets set on an annual basis. The budget targets are the sum of two components: (1) the projected "per member per month" (PMPM) costs of those who would have been eligible absent a waiver (non-expansion eligibles) and (2) the projected disproportionate share hospitals (DSH) expenditures. Specific growth rates for the PMPM costs were determined for four categories of assistance of non-expansion eligibles: Families, Disabled, Massachusetts Commission for the Blind (MCB) members and 1902(r)(2) populations. The budget neutrality cap is determined by multiplying these PMPM rates times the number of non-expansion eligibles (See Attachment 6). Over the five year Waiver period, annual expenditures for the Waiver population averaged 93% of the total annual expenditures allowed under the budget neutrality cap. As a result, total Waiver expenditures during the initial 5-year period are expected to fall $1.055 billion below the allowed budget neutrality cap. However, if the trends used to calculate allowable expenditures under budget neutrality are not increased, Waiver expenditures are expected to surpass allowable spending on an annual basis for each year of the waiver extension period. (See Attachment 7)

Historical Trends

Historically, spending for the Commonwealth's Demonstration program remained under the budget neutrality cap because spending for Families was lower than that allowed by the PMPM trend for that category. PMPM spending for Families grew at an annual average of 3.6% over the course of the waiver, a significantly lower growth rate than the 7.1% allowed for budget neutrality. However, spending for the Disabled and MCB populations grew at an average of 8.02% and 9.25% per year, respectively, a number significantly higher than the 5.83% budget neutrality trend. The lower spending in the Families population therefore allowed for spending above the PMPM trend line for the Disabled and MCB populations (See Table 3).

Table 3: Change in budget neutrality trends and actual PMPM expenditure growth rates

Population	Waiver Year 2 (SFY 99)	Waiver Year 3 (SFY 00)	Waiver Year 4 (SFY 01) Projected	Waiver Year 5 (SFY 02) Projected
Disabled Budget Neutrality Trend	*5.83%*	*5.83%*	*5.83%*	*5.83%*
Disabled Actual	**11.0%**	**7.1%**	**7.0%**	**7.0%**
Families Budget Neutrality Trend	*7.71%*	*7.71%*	*7.71%*	*7.71%*
Families Actual	**-2.0%**	**4.5%**	**6.0%**	**6.0%**
MCB Budget Neutrality Trend	*5.83%*	*5.83%*	*5.83%*	*5.83%*
MCB Actual	**15.9%**	**7.1%**	**7.0%**	**7.0%**

New Trend Request

Although Demonstration costs were kept well within the budget neutrality cap over the initial waiver period, they are not likely to continue to do so for the 3-year waiver extension period without an increase in the trend lines. Two areas are contributing to high cost growth -- pharmacy costs and provider rate pressures. In general, pharmacy costs have increased at the greatest rate over the past 4 years and are expected to be the main driver behind increased PMPMs for all populations in the next 4 years. Spending for behavioral health, acute medical care and transportation services, which has increased at moderate levels during the waiver period, is expected to grow at a faster rate in the future in response to increased pressure from providers to raise payment rates. After a period of low inflation in the 1990s, the Division is now experiencing tremendous pressure from all providers to increase rates due to nursing shortages and wage pressures. The medical growth Consumer Price Index (CPI) for Massachusetts and surrounding states[4] is 7.1%, while only 4.9% nationally.

Over the Waiver Extension period, we expect the PMPM for Families to grow by 8.3% annually (see detailed description of projection methodology below). The expected growth in Family PMPM costs will eliminate the gap between actual spending for Families and the PMPM trend allowed under budget neutrality. This gap allowed the Waiver program to remain budget neutral even though the PMPM spending for the disability category increased above the allowable PMPM trend for the Disabled population. As the gap disappears, then, an increase in the Disabled PMPM trend will be necessary to reflect the true spending for the Disabled population. Additionally, spending for the Disabled population is expected to continue to grow by 12.7% per year in over the next three years.

As shown in Table 4, to accommodate the expected growth of PMPM expenditures, the Division requests that the budget neutrality trends for both Family and Disabled categories be increased to 8.3% and 12.7%, respectively. The Division requests a blended rate for the 1902(r)(2) population of 9.2%, reflecting that the population is a mix of Families and Disabled. Additionally, the Division requests that MCB members be considered as Disabled members for budget neutrality purposes.[5]

[4] The surrounding states are New Hampshire, Maine and Connecticut.

[5] The MCB and Disabled population are substantially similar and have historically had the same trend line. For administrative ease, the Division requests that the MCB be included in the Disabled group. The Division is not aware of a reason that would require the groups to remain separated.

Table 4. Budget Neutrality Trend Request[6]

Population	Waiver Year 6 (SFY 03) Projected/Requested Trend	Waiver Year 7 (SFY 04) Projected/Requested Trend	Waiver Year 8 (SFY 05) Projected/Requested Trend
Disabled Budget Neutrality Trend Request	12.7%	12.7%	12.7%
Disabled & MCB Projected	**12.1%**	**12.7%**	**13.3%**
Families Budget Neutrality Trend Request	8.3%	8.3%	8.3%
Families Projected	**8.1%**	**8.7%**	**9.3%**

PMPM Trend Projections

The Division calculated projected trends for each population by provider category and projecting each forward. The provider categories are pharmacy, behavioral health, acute medical and transportation.

Trend projections are made using expenditure and claims data from Standard Family and Standard Disabled populations who are managed care eligible and not enrolled in a contracted MCO[7]. Spending for these populations were chosen as a proxy for spending for all Family and Disabled populations primarily because spending trends for these populations are likely to reflect both rate and utilization trends for the Standard populations. By contrast, spending trends for Standard populations who are not managed care eligible may reflect fluctuations in payments by third party payers. Additionally, claims data is most readily available for these managed care eligibles, making it easier to tie overall spending trends to spending categories. Attachment 8 shows historical and projected PMPM spending information for Standard Disabled and Standard Family populations by four categories: pharmacy, behavioral health, acute medical care, and transportation. The following three sections explain in more detail the Division's reasons for the increased trend request.

Pharmacy

Per member expenditures on pharmaceuticals have increased at double-digit rates since SFY1996 for both Families and Disabled populations. Since pharmacy

[6] As described on page 27, trend projections are made using expenditures and claims data from Family and Disabled populations who are managed care eligible and not enrolled in a contracted MCO.

[7] Also referred to as PCC Standard Enrolled and Unenrolled Populations

expenditures are already a large proportion of spending, accounting for almost one third of dollars spent per disabled member, continued high rates of growth for pharmacy expenditures are expected to disproportionately drive up the total PMPM cost for each population.

The trend in increased drug costs is not specific to MassHealth. Research has shown that pharmaceutical costs are increasing for most health purchasers nationally because of: 1) an increase in the price of existing drugs; 2) an increase in the average number of drugs prescribed for individuals; and 3) a tendency for individuals to be prescribed new, more expensive drugs for similar ailments as these medications become available.[8] Massachusetts' experience is consistent with national trends in the cost and utilization of prescription drugs. Nationally, spending on pharmaceuticals for all payers increased by 84% between 1993 and 1998.[9] The National Pharmaceutical Council reported that between 1994 and 1998 average Medicaid pharmacy costs throughout the nation increased by over 50%.[10] These trends are not expected to abate in coming years.

Table 5 shows the per member pharmacy spending trends for individuals who are eligible for Standard benefits and are either enrolled in the PCC Plan or are eligible for managed care but have not enrolled. Projections for Disabled populations were made based on SFY99 and SFY00 spending patterns. More weight was given to SFY00 because we expect pharmacy trends to increase at a faster rate over time. Additionally, a "sensitivity factor" was added in to allow for an expected future increase in the rate of PMPM cost growth.

Projections for PMPM costs for Families were made using the same basic methodology. However, future projections were trended off of SFY00 alone because historical fluctuations in program growths are believed to have skewed past PMPM costs for Families. MassHealth experienced tremendous caseload growth from July 1997 to July 1999: the total MassHealth caseload grew by 11% and 14%, respectively during these two years. If one divides total spending by total caseload during those two years, it appears that the per member per month (PMPM) costs were declining. More careful analysis, however, revealed that the PMPM cost decline was due primarily to the huge increase in our caseload, which immediately increased the denominator in the equation, thereby artificially undervaluing the PMPM cost.

[8] The Henry J. Kaiser Family Foundation, Prescription Drug Trends: A Chartbook, July 2000.
[9] Barents Group, LLC, "Factors Affecting the Growth of Prescription Drug Expenditures", July 1999.
[10] National Pharmaceutical Council, Pharmaceutical Benefits Under State Medical Assistance Programs, 1999.

Table 5: Pharmacy PMPM Trends by Population and SFY(97-05)

SFY	Families	Disabled
SFY97	21.6%	21.9%
SFY98	12.0%	20.6%
SFY99	20.3%	16.5%
SFY00[11]	23.6%	19.9%
SFY01(estimated)	25.8%	22.6%
SFY02(projected)	25.8%	22.6%
SFY03(projected)	25.8%	22.6%
SFY04(projected)	25.8%	22.6%
SFY05(projected)	25.8%	22.6%

From FY1997 to FY1999 the cost per prescription for MassHealth members increased significantly. The increase in price per prescription is related to the rising cost of drugs throughout the nation, particularly in the therapeutic categories most used by MassHealth members. Between 1993 and 1999, total expenditures in the United States for all drugs increased by 84%. During that same period of time, expenditures for anti-depressants and anti-psychotics increased by 241% and 462%, respectively.[12] While some of this increase may be due to increased nationwide utilization of these therapeutic categories of drugs, most of the increase is the result of newer, more costly, medications with fewer side effects. Since MassHealth spends more money on anti-depressant drugs and anti-psychotic drugs than on any other therapeutic category, our spending is disproportionately impacted, contributing to the dramatic spending increases. MassHealth's high growth rates on per member expenditures for pharmaceuticals are expected to continue in the future.

Provider Rate Pressure

PMPM spending trends for most other provider types have historically remained relatively flat. However, Medicare payment policy changes, increased difficulty in provider retention and recruitment of staff, and the cumulative effect of a decade of cost controls by all payers, have contributed to increased Medicaid rate pressure from providers. Pressure from providers for rate increases poses a challenge for the Division this year and in future years and will require significant attention. The major impact of provider rate increases on projected FY2001 MassHealth spending is increases in costs associated with acute hospital care, community health centers, and dental services.

As with pharmacy expenditures, expected rate increases are consistent with national trends. The Kaiser Family Foundations' issue paper "Medicaid Spending Growth Remained Modest in 1998, but Likely Headed Upward," lists pressure for

[11] Per member per month expenditures for FY2000 were adjusted upwards from actual data for that year to adjust for a systems problem

[12] This indicates increases in the therapeutic category of drugs, and therefore includes both existing drugs and newly introduced drugs. Barents Group, LLC, "Factors Affecting the Growth of Prescription Drug Expenditures", July 1999.

provider rate increases as a major driver of increased state spending growth. This article suggests that the ability of state Medicaid programs to control growth by limiting increases in provider payments may be ending. Where, on average, national Medicaid per member expenditures grew by about 6% between FFY1995 and FFY1997, and by almost 7% from FFY1997-FFY1998, the Congressional Budget Office projects that future federal Medicaid spending expenditures will grow at an annual average rate above 8%. While Massachusetts's per member expenditure growth rate tends to lag behind this national average for both Families and Disabled population categories, it will not continue to do so indefinitely. Indeed, the recent provider rate increases described above are likely a reaction to low historic rate increases to providers. One prime example of provider pressure can be seen in case of ambulance service providers, who recently sued the Commonwealth in order to increase rates.

Despite this deflation, the increase in the trend for PMPM expenditures for the Disabled population can be seen beginning in FY1999. This recent increase of what has historically been a lower trend will likely contribute to an overall increased PMPM trend rate in the future. Trends for acute medical care, shown in Table 6, were projected using the same methodology that was used to project pharmacy trends.

Table 6: Acute Medical Care PMPM Trends by Population and SFY (97-05)

SFY	Families	Disabled
SFY97	1.5%	-2.6%
SFY98	-4.8%	-1.5%
SFY99	-2%	3.7%
SFY00[13]	2.7%	3.7%
SFY01(estimated)	4.0%	5.7%
SFY02(projected)	4.0%	5.7%
SFY03(projected)	4.0%	5.7%
SFY04(projected)	4.0%	5.7%
SFY05(projected)	4.0%	5.7%

Behavioral Health

Behavioral Health PMPM expenditures have slowly but steadily increased over the Waiver period. These expenditures are expected to continue to grow over the extension period for two major reasons. First, a growing number of children who are likely to need those and other more intense mental health services, specifically children in the care and custody of the state, are entering MassHealth's rolls. Additionally, as with acute medical services, the ability of the state to impose cost controls on providers is expected to wane.

[13] Per member per month expenditures for FY2000 were adjusted upwards from actual data for that year to adjust for a systems problem

Children who are in the care and custody of the state place particular cost pressures on the Division. On average, the PMPM behavioral health costs of children in the care and custody of the state are five times the PMPM behavioral health costs for other children. Costs for this population tend to be higher than average in general because this population tends to need more services. These costs are exacerbated because an insufficient number of psychiatric residential placements for children leads to longer, more costly hospital stays.

The Division is also experiencing pressure from its behavioral health contractor to increase rates. Primarily, a rate increase would be used to preserve the contractor's provider network to ensure adequate access to services. Although a rate increase was granted in SFY01, it was not sufficient to meet annual medical CPI adjustments.

The continued pressure from providers to increase rates combined with the expected influx of children who use behavioral health services at higher than average rates will increase behavioral health PMPM cost trends in the future. The introduction of these factors into the behavioral health system will likely drive up future costs more quickly than historical trend rates would suggest. As seen in Table 7, future PMPM costs for behavioral health are expected to increase more quickly than they have in the past.

Table 7: Behavioral Health PMPM Trends by Population and SFY (97-05)

SFY	Families	Disabled
SFY97	-5.3%	13.0%
SFY98	0.5%	1.9%
SFY99	4.7%	1.9%
SFY00[14]	1.8%	2.5%
SFY01(estimated)	6.5%	5.9%
SFY02(projected)	6.5%	5.9%
SFY03(projected)	6.5%	5.9%
SFY04(projected)	6.5%	5.9%
SFY05(projected)	6.5%	5.9%

7. Adequacy of Financing and Reimbursement

The Division provides services for the Demonstration primarily through managed care settings. Members are enrolled in either the PCC Plan, which is run by the Division, or a contracted MCO. Additionally, members enrolled in the PCC Plan receive behavioral health services through a subcontracted capitated program. The state sets payment rates for services provided by PCC Plan so that these rates are sufficient to meet costs incurred by an efficient and economically operated provider of the service in an open and competitive marketplace. Capitation

[14] Per member per month expenditures for FY2000 were adjusted upwards from actual data for that year to adjust for a systems problem

payments made to contracted MCOs are a percentage of the Upper Payment Limit (UPL). The UPL reflects the Medicaid PCC rates that DMA pays to its providers. MCOs are then permitted to pay their subcontractors and providers within their network at rates commensurate with the business plan and strategy of the MCO.

Access to services is available in every area of the state though either the PCC Plan and/or contracted MCO plans. To monitor the adequacy of the finance and reimbursement methods plans, the state evaluates the capacity of these programs through a capacity reporting process. Capacity reports for the PCC plan are done every 6 months. PCC capacity reports show that in March 2001, 88% of the PCC sites were accepting new MassHealth members. To monitor access within the PCC's behavioral health capitated program, the Division also conducts annual surveys of both providers and members. These surveys show that providers are satisfied with the financing and reimbursement process of the Division. The vast majority of members report that they are able to get needed care. Similarly, capacity reports are compiled for MCOs on a quarterly basis. Additionally, Division staff review MCO specialty care provider networks.

The Division makes every effort to correct access problems as they are identified. For example, in SFY01, the Division redesigned the acute treatment system for substance abuse in response to a provider proposal. Included in this redesign was a rate increase. Similarly, the Division is attempting to lower the financial burden on hospitals treating children who are "stuck" at an inpatient level of care while awaiting residential psychiatric treatment programs by increasing the compensation to those hospitals. While the availability of all psychiatric treatment for children is a problem across the nation, the Division works with providers in this way to lower the negative financial impact on the system. Additionally, the Division is working with providers to increase capacity for psychiatric treatment for children, at the inpatient level and at the community level, within the state.

The Division is also working to eliminate access problems within the Dental program, where a combination of factors, including but not limited to lower than industry average reimbursement rates, have contributed to limited access to dental care for MassHealth members. DMA has been working intensively with the Dental Association as well as other advocates and health care providers to increase dental participation in the MassHealth program. To improve access to dental services among MassHealth members, DMA developed the "MassHealth Dental Plan." Components of the MassHealth Dental Plan include fee increases; administrative reforms to make MassHealth more "provider friendly" to dentists; infrastructure reform to help improve dental participation in low access areas of the state; and programmatic initiatives make it easier for dentists to incorporate MassHealth members into their current practices. Since the inception of the MassHealth Dental Plan, the Division has made significant improvements in its dental program. A rate increase in FY01 brings the MassHealth dental fees from approximately 45% of private charges to approximately 60-65% of private

charges. The Division intends to provide a subsequent rate increase in FY02 to bring dental fees up to 80% of private charges.

B. Public Notice

The Division has complied with CMS's public notice requirements regarding this request for an extension to the 1115 Demonstration Waiver.

1. **Public Notice Process**
   The Division published a notice in the Massachusetts Register on April 13, 2001 (See Attachment 9). The notice directed the public and interested parties to both the Division's web site to get a copy of the Division's announcement of its intention to request an extension to its 1115 Demonstration. (See Attachment 10) A phone number was also provided where persons could request a paper copy of the document. In addition, the notice provided instructions on where to address comments on the extension request. The public comment period ran for 30 days between April 13, 2001 and May 11, 2001.

   In addition, the Division mailed letters to key stakeholders regarding the public notice period and included the extension announcement. Letters were mailed to the Mass. Congressional Delegation; key state legislators; sister state agencies; advocacy groups with whom the Division interacts on Health Care Reform issues; and provider and trade associations.

2. **Written Comments Received During Public Notice**
   The Division received 4 letters in response to its public notice. The letters are attached as Attachment 11.

3. **Response to Public Comments**
   The Division has responded to each of the letters received during the public notice process. These responses are attached as Attachment 12.

C. Attachments

Attachment 1 – Special Terms and Conditions

Attachment 2 – 1999-2000 MassHealth Managed Care Member Survey

Attachment 3 – MEQC; Section 2.5 of the Protocol Document as submitted 6/28/01

Attachment 4 – IP Employer Survey, Section 7.6 of the Protocol Document as submitted 6/28/01

Attachment 5 – Counting Conventions; Section 9.7 of the Protocol Document as approved 6/28/01

Attachment 6 – Federal Budget Neutrality – Waiver Expenditures

Attachment 7 – Federal Budget Neutrality Summary Using Original Trends

Attachment 8 – Calculation of New Trend Request

Attachment 9 – Public Notice

Attachment 10 – Document Announcing 1115 Demonstration Extension Request

Attachment 11 – Letters Received During Public Notice Period

Attachment 12 – Responses to Letters Received During Public Notice Period